Report to the Idaho Council on Children's Mental Health

July 1, 2002

From
The School-Based Children's Mental Health Workgroup

Submitted by

The Idaho State Department of Education

Bureau of Special Education

Purpose

The purpose of this work group was to satisfy Recommendation #6A of the Children's Mental Health Implementation Plan. This recommendation is as follows:

Recommendation #6A:
By July 1, 2001, the ICCMH will establish a workgroup led by SDE, with specific directions to develop recommendations for using schools to improve identification of children with mental health needs and to provide a base for service delivery. Recommendations will be presented to the Council by July 1, 2002 and should focus on models of other states, identification of space availability, transportation issues, seasonal issues and methods of integrating services and education.

Proposal:
The State Department of Education (SDE) will convene a task force (up to15 members) with representation from the following:

- State Department of Education
- Parents of students identified as ED
- Idaho School Administrator/Special Education Directors
- Idaho Education Association
- Central and Regional Department of Health and Welfare, Children's Mental Health
- Department of Juvenile Corrections
- Idaho Mental Health Planning Council
- Positive Behavior Support Project (U of I)
- Private providers

Following a review of other state models and the literature, the task force will develop and conduct a survey of people from randomly selected communities in Idaho to determine their interests and needs for school based children's mental health services. Using data from the survey and the review of models and literature, the task force will make recommendations to the ICCMH for their action by July 1, 2002.

Workgroup Membership

Name	Constituency
Mert Burns	Special Education Director
Ross Edmunds	Mental Health Specialist Idaho Dept. of Health and Welfare
Julie Fodor	Director, Center on Disabilities and Human Development, University of Idaho
Michael Friend	Executive Director Idaho Association of School Administrators
Claudia Hasselquist	Coordinator, Safe and Drug Free Schools Idaho State Dept. of Education
Linda Hatzenbuehler	Dean, College of Health Professions Idaho State University
Kim Hegg-James	Parent
Linda Johann	Parent
Fred Kirn	Children's Mental Health, Chief DHW, Region 7
Ken Olsen	Special Education Director
Glenda Rohrbach	Education Coordinator Idaho Dept. of Juvenile Corrections
Russell Hammond	Special Education Director
Laura Sandidge	Project Coordinator (Private Provider) Intensive Behavior Interventions
Sally Tiel	Coordinator, Counseling and Assessment Idaho State Dept. of Education
Robert West	Chief Deputy Superintendent Idaho Dept. of Education
Susan Haffner	Regular Education Teacher
Kathy Phelan	President Idaho Education Association
Jana Jones	Chief, Bureau of Special Education Idaho State Dept. of Education
Mary Bostick	Regional Special Education Consultant Boise State University
Barbara Funston	Consulting Teacher
Ann Kirkwood	Consultant Idaho State University
Russ Hammond	Coordinator, Personnel Development Idaho State Dept. of Education

Workgroup Meetings and Activities

Date	Event	Activities
August 21, 2001	First workgroup meeting	1. Review the purpose. 2. Review available data. 3. Share literature to review. 4. Generate list of questions for a survey.
October 18, 2001	Sub-committee meeting	1. Review Literature. 2. Formulate survey model.
November 1, 2001	Second workgroup meeting	1. Review Literature. 2. Agree upon survey format and questions.
January to February 2002	Survey	Distribute Survey and collect responses.
March 2002	Survey	Tabulate Data.
April 18, 2002	Sub-committee meeting	1. Analyze survey data. 2. Develop broad conclusions.
May 9, 2002	Third workgroup meeting	1. Analyze results of the survey. 2. Brainstorm recommendations. 3. Prioritize recommendations. 4. Draft language for recommendations.
June 13, 2002	Fourth workgroup meeting	1. Review workgroup purpose. 2. Review a concept paper from The National Association of State Mental Health Program Directors and The Policymaker Partnership for Implementing IDEA at The National Association of State Directors of Special Education. 3. Continue to prioritize and draft language for recommendations.
July 2, 2002		Draft report sent to Workgroup members for input.
July 16, 2002		Submit Report to the ICCMH.

Literature Review

While twenty percent of all youth may experience a diagnosable emotional disorder, nine to thirteen percent of these youth will experience a serious emotional disturbance with substantial functional impairment; of that number, five to nine percent will experience a serious emotional disturbance with extreme functional impairment.

A national study has not been conducted to examine the prevalence of SED among youth. However, in 1996 Friedman and his colleagues analyzed the results of studies that examined the prevalence of SED in a variety of communities. This investigation concluded that approximately 20 percent of all children and youth have a diagnosable mental disorder.

Friedman and colleagues further delineated the estimated range of children who experience an emotional disorder into two smaller groups based on the amount of impairment associated with the disorder**.** While 20 percent of all youth may experience a diagnosable emotional disorder, 9-13 percent of these youth will experience a serious emotional disturbance with substantial functional impairment, of that number, 5-9 percent will experience a serious emotional disturbance with extreme functional impairment.

Further, Friedman asserts that poverty levels and other measures of low socio-economic status may affect the number of children with emotional disorders, and he advises communities with these characteristics to use the high end of the ranges provided to estimate prevalence of youth with emotional disorders. The *1999 Surgeon General's Report on Mental Health* seems to corroborate the Friedman estimates in reporting that approximately one in five children and adolescents experiences signs and symptoms of a diagnosable disorder during the course of one year, but only 5% of all children experience "extreme functional impairment." Today, the Center for Mental Health Services (CMHS) still refers to the Friedman study in assisting states to begin planning for services by determining prevalence rates for children and youth with emotional disorders.

Likewise, The Policy Leadership Cadre for Mental Heath in Schools, a group of experts under the auspices of the Center for Mental Health in Schools at UCLA, notes that large discrepancies exist across socio-economic levels. They reviewed a number of school and mental health data reports and concluded that the number of students with psychosocial problems "in many schools serving low-income populations has climbed over the 50 percent mark, and few public schools have fewer than 20 percent who are at risk."

(The National Association of State Mental Health Program Directors and the Policymaker Partnership for Implementing IDEA at the National Association of State Directors of Special Education, 2001. p. 2)

Only a small percentage of children who are estimated to have a diagnosable emotional disorder are actually receiving mental health services in schools across the nation. In Idaho, less than one percent (.38 %) of the publicly enrolled children is identified as having an emotional disturbance and is on an IEP.

> The U.S. Department of Education reported that during the 1998-1999 school year more than 463,000 children ages 6-21 with emotional disturbances were served in the public schools nationwide. These are only those students who were identified under the Individuals with Disabilities Education Act (IDEA), Part B, under the category of Emotional Disturbance (U. S. Department of Education, 2000.) Additional undetermined numbers of children with psychosocial, emotional-behavioral or severe mental health problems are also served under other disability categories, such as "Other health impaired" and various learning disabilities. In addition, other students are receiving mental health services in schools who are not categorized as disabled under the provisions of IDEA. Even so, the percentage of students with serious behavioral or emotional disabilities who receive mental health services is extremely low. According to a number of experts, at least 3-5 percent of school children are considered to have serious behavioral or emotional disabilities that require intensive coordinated services; however, it is estimated that less than 2 percent of these students receive any mental health services (Hoagwood and Erwin, 1997). For youth in the juvenile justice system the picture is even worse. The prevalence of youth with emotional disabilities is estimated to be at least three to five times greater in juvenile correctional facilities than in public schools (Leone and Meisel, 1997).
>
> (The National Association of State Mental Health Program Directors and the Policymaker Partnership for Implementing IDEA at the National Association of State Directors of Special Education, 2001. p. 3)

Mental health services in the schools are one element of a comprehensive, multifaceted continuum of programs and services that schools need to enable effective learning and teaching.

> It is not a new insight that physical and mental health concerns of students must be addressed if schools are to function satisfactorily and if students are to learn and perform effectively. Currently, there are almost 91,000 public schools in about 15,000 districts. Over the years, most (but obviously not all) schools have instituted programs designed with a range of mental health and psychosocial concerns in mind (e.g., school adjustment and attendance problems, dropouts, physical and sexual abuse, substance abuse, relationship difficulties, emotional upset, delinquency, violence). School-based and school-linked programs have been developed for purposes of early intervention, crisis intervention and prevention, treatment, and promotion of positive social and emotional development. A large body of research supports the promises of many of the approaches that schools are pursuing. On another level is the reality that for some

youngsters, schools are the main providers of mental health (MH) services. As Burns and her colleagues (1995) found in their study of children's utilization of mental health services in western North Carolina, "the major player in the *de facto* system of care was the education sector—more than three-fourths of children receiving MH services were seen in the education sector, and for many this was the sole source of care."

At the same time, there continues to be concern about the place of mental health in schools. Among some segments of the populace, schools are not seen as an appropriate venue for mental health interventions. The reasons vary from concern that such activity will take time away from the educational mission to fear that such interventions are another attempt of society to infringe on family rights and values. There also is the long-standing discomfort so many in the general population feel about the subject of mental health–which often is viewed only in terms of mental illness. And, there is a historical legacy of conflict among various stakeholders stemming from insufficiently funded legislative mandates that have produced administrative, financial, and legal problems for schools and problems of access to entitled services for some students.

Whatever one's position is about mental health in schools, we all can agree on one simple fact: *schools are not in the mental health business.* Education is the mission of schools, and policymakers responsible for schools are quick to point this out when they are asked to do more about physical and mental health. It is not that they disagree with the idea that healthier students learn and perform better. It is simply that prevailing school accountability pressures increasingly have concentrated policy on instruction practices—to the detriment of all matters not seen as *directly* related to raising achievement test scores. Given these realities, the case for mental health in schools probably is best made by not presenting it separately, but embedding it as one element of a comprehensive, multifaceted continuum of programs and services that schools need to enable effective learning and teaching. Such a continuum encompasses efforts both to promote healthy development and address barriers to development, learning, parenting, and teaching. Properly developed and implemented, a focus on mental health in schools can contribute toward ensuring all students have an equal opportunity to develop to their fullest cognitive, social, and emotional capabilities.

(Policy Leadership Cadre for Mental Health in Schools, 2001. pp. 3-4)

In order for children and youth to be identified and their needs to be addressed, schools, families, child-serving agencies, and the broader community must work together. The following is an example of a vision statement for a shared education and mental health agenda:

Schools, families, child-serving agencies, and the broader community will work collaboratively to promote opportunities for and to address barriers to healthy

social and emotional development and learning. The project's aims are to ensure that:

- All children and youth (including infants, toddlers, and preschoolers) have an equal opportunity to develop to their fullest cognitive, social, and emotional capacities; and
- The needs of those who experience psychosocial problems and emotional and behavioral disabilities are effectively addressed.

Schools, families, child-serving agencies, and the broader community will be continually involved in shaping policies, practices and strategies to develop comprehensive, multifaceted, and cohesive approaches that encompass systems of:

- Positive development of children (including infants, toddlers, and preschoolers), youth, families, and communities, and prevention of problems;
- Early identification—interventions for children (including infants, toddlers, and preschoolers) and youth at risk or shortly after the onset of problems; and
- Intensive interventions.

Such approaches will be integrated and will not only meet the needs of children and youth, but will also help strengthen the nation's families, schools and neighborhoods.

(The National Association of State Mental Health Program Directors and the Policymaker Partnership for Implementing IDEA at the National Association of State Directors of Special Education, 2001. p. vii)

The foundation of a shared agenda is a common conceptual framework that is adopted by the intervention partnerships.

Common frameworks help shape policy in consistent, congruent, and cohesive ways. Successful intervention partnerships need to adopt a common conceptual framework for meeting the complex needs of all children, youth and their families. A conceptual framework provides the basis for clearly articulated policy and should drive the implementation of a shared agenda in ways that yield a comprehensive, multifaceted and cohesive continuum of interventions.

The multi-tiered framework described below is based on a public health model. It provides a comprehensive foundation upon which to build a shared agenda among family organizations and state mental health and education agencies.

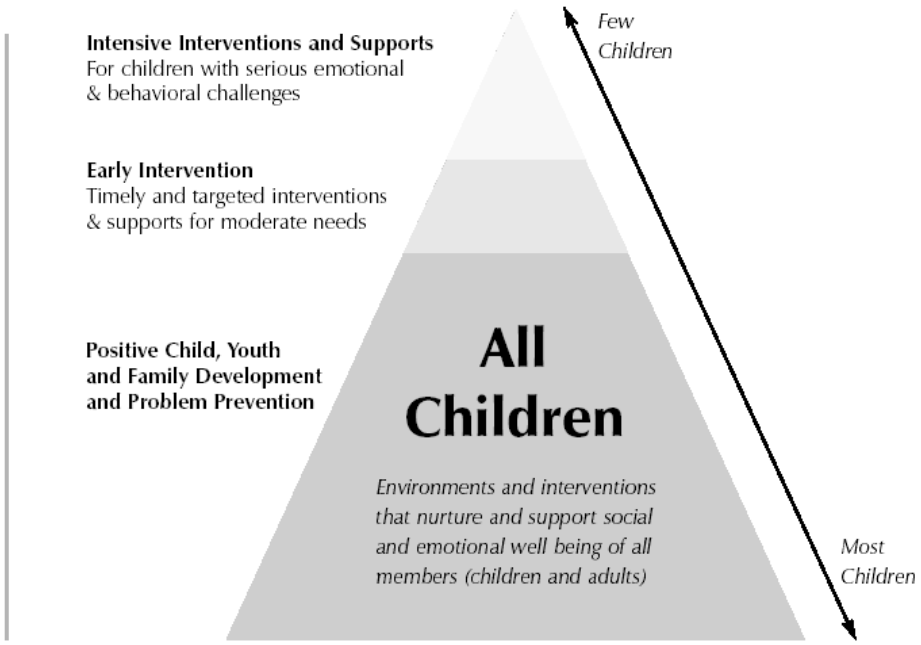
A number of initiatives within different federal agencies have adopted the core aspects of this particular public health model. These initiatives use somewhat different language in describing the three major tiers or levels of intervention or activities, but all of them agree on the notion of a continuum of services or

systems that is necessary in meeting the social, emotional and mental health needs of all children and youth.

The framework below differentiates three basic levels of intervention:

1. Positive child, youth, and family development and prevention of problems;
2. Early intervention; and
3. Intensive interventions and supports.

THE MULTI-TIERED FRAMEWORK



Promoting Positive Development and Prevention

All systems that support children and youth must be concerned with promoting social-emotional development and learning. This includes parenting and formal programs that teach social and problem-solving skills and encompasses enrichment and recreation programs, both during school and before and after school. This also involves training teachers and staff on how to support positive school and classroom behavior. Creating and sustaining a supportive environment for children and youth is a community-wide responsibility, because the school is a critical part of that environment. Activities that create a sense of community through personal relationships and connections help create safe and supportive environments. School and service agency personnel can model appropriate behaviors, create a climate of emotional support, and demonstrate commitment to working with all youngsters. Equally important, personnel must be provided with support and assistance in sustaining a healthy school and service agency climate.

Problem Prevention
Preventing foreseeable and recurring problems include promoting healthy development and safe environments. It also includes creating systems of prevention for all children and families. Examples of programs to promote positive development and prevent problems are: welcoming and social support programs for new students and their families, values-based alcohol and drug education and support for transitions and child abuse education. In some schools and communities, the majority of students will require no more than this first level of intervention.

Early Intervention
This level involves addressing emotional and behavioral problems children experience at an early age and intervening as soon as a problem occurs, no matter what the age of the child. Examples include small group activities, behavioral support plans, after school programs and dropout re-entry programs.

Intensive Interventions and Supports
This level includes more intense, sustained services and supports for children who experience severe, persistent, or chronic emotional or behavioral disabilities (about three to five percent of all children). These children and youth and their families usually require individualized multidisciplinary and multi-agency service plans to access a coordinated system of care. Examples of strategies within a service plan include intensive home-based services, respite care, individual, group, and family therapy, therapeutic foster care, crisis intervention, intensive after-school programs and in-school aides, all of which are linked through service coordination.

This multi-tiered framework is a helpful way to conceptualize the continuum of services and interventions, and to recognize them as a coherent system. Arguing over whether a particular intervention fits into one level or another is counterproductive. For instance, whether any school-wide activity is "prevention" or "positive youth development" for purposes of our discussion is not as important as understanding that all systems must conceptualize and build a continuum of interventions as complete as possible, from the least intensive and restrictive to the most intensive and restrictive.

The multi-tiered framework described is the foundation for a number of federally supported systems change initiatives and programs. These include the following:

Education
- *Safeguarding our Children*, 2000, Departments of Education and Justice
- The Technical Assistance Center on Positive Behavioral Interventions and Supports (PBIS)
- The National Center on Education, Disability, and Juvenile Justice (EDJJ)
- The Center for Effective Collaboration and Practice (CECP)

Mental Health

- *Building Bridges of Support: One Community at a Time*, a five-year grant to parts of Appalachian Kentucky under the Comprehensive Community Mental Health Services for Children and Their Families Program, funded by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.
- Policy Leadership Cadre for Mental Health in the Schools, *Mental Health in Schools: Guidelines, Models, Resources, and Policy Considerations*, 2000.

The Promise of a Conceptual Framework

The multi-tiered framework provides a foundation for mapping policy and program development. It is a commonsense approach that can apply to all programs and services. The framework represents a conceptual shift and grounds a shared vision of systemic interventions that drive the planning and implementation of services directed toward the well being of all children. Moreover, if positive child and youth development, problem prevention, and early intervention strategies are in place and students receive the kind of help they need earlier, fewer children will need intensive interventions. Using a common and comprehensive framework, mental health and school staff can appreciate and pursue a more integrated role in comprehensive school-wide efforts to meet the social-emotional needs of all students. Mental health workers practice what they know best—conducting psychological evaluations, or individual and group therapy—and too often see little opportunity to address the environment in which they are working. As "insiders," these mental health workers can become knowledgeable about how the school is organized and works, be co-trained with school personnel on school-wide approaches and integrate all their efforts into the school's culture. They will work with the schools not only to identify and seek intensive mental health services for those students who need them, but also as a part of the school's comprehensive, multi-faceted, and integrated approach for all students. Education, mental health systems, families and youth can join together. They already are doing so in communities around the nation. Through shared initiatives, they are addressing barriers to learning and improving the lives of all young people. It is time to move to action in every community and school.

(The National Association of State Mental Health Program Directors and the Policymaker Partnership for Implementing IDEA at the National Association of State Directors of Special Education, 2001. p. 21-23)

Model Programs

The School-based workgroup reviewed literature on the following school-based or school-linked programs:

- The South Philadelphia Family Partnership. (Woodruff, 17-27)
- East Baltimore Mental Health Partnership School Based Program. (Woodruff, 27-37)
- Project REACH: Rhode Island. (Woodruff, 37-63)
- Yale Child Center Model. (MDI Associates, 29)
- Project "ACHIEVE": Florida. (MDI Associates, 30-31)
- Wraparound Project: LaGrange, Illinois. (MDI Associates, 32)
- Primary Mental Health Project: New York. (MDI Associates, 33)
- School Based Youth Service Program: New Jersey. (MDI Associates, pp. 34-35)
- Integrated Resource in Schools (IRIS): Kentucky. (Adelman, 1999, p. 104)
- School Linked/School Based Mental Health Services Project: Maine. (Adelman, 1999, p. 105)
- State and Local Partnership for Mental Health in Schools: Minnesota. (Adelman, 1999, p. 105)
- School Mental Health Initiative: New Mexico. (Adelman, 1999, p. 106)
- MCHB Public-Academic Partnership Program: South Carolina. (Adelman, 1999, p. 107)
- Linn County Youth Services Team. Oregon. (Linn Benton Lincoln Education Service District, 2000)

The following mechanisms and formats are the five most common methods for the delivery of mental health services in schools:

1. School-Financed Student Support Service–Most school districts employ pupil services professionals such as school psychologists, counselors, social workers, and school nurses to perform services related to mental health and psychosocial problems (including related services designated for special education students). The format for this delivery mechanism tends to be a combination of centrally-based and school-based services.

2. School-District Mental Health Unit–A few districts operate specific mental health units that encompass clinic facilities, as well as providing services and consultation to schools. Some others have started financing their own School-Based Health Centers with mental health services as a major element. The format for this mechanism tends to be centralized clinics with the capability for outreach to schools.

3. Formal Connections with Community Mental Health Services–Increasingly, schools have developed connections with community agencies, often as the result of the school-based health center movement, school-linked services initiatives (e.g., full service schools, family resource centers), and efforts to develop systems of care ("wrap-around" services for those in special education). The following four formats have emerged:

- Co-location of community agency personnel and services at schools–sometimes in the context of School-Based Health Centers partly financed by community health organizations;

- Formal linkages with agencies to enhance access and service coordination for students and families at the agency, at a nearby satellite clinic, or in a school-based or linked family resource center;

- Formal partnerships between a school district and community agencies to establish or expand school-based or linked facilities that include provision of MH services; and

- Contracting with community providers to provide needed student services.

4. Classroom-Based Curriculum and Special "Pull Out" Interventions–Most schools include in some facet of their curriculum a focus on enhancing social and emotional functioning. Specific instructional activities may be designed to promote healthy social and emotional development and/or prevent psychosocial problems such as behavior and emotional problems, school violence, and drug abuse. And, of course, special education classrooms always are supposed to have a constant focus on mental health concerns. The following three formats have emerged:

   - Integrated instruction as part of the regular classroom content and processes;

   - Specific curriculum or special intervention implemented by personnel specially trained to carry out the processes; and

   - Curriculum approach as part of a multifaceted set of interventions designed to enhance positive development and prevent problems.

5. Comprehensive, Multifaceted, and Integrated Approaches–A few school districts have begun the process of reconceptualizing their piecemeal and fragmented approaches to addressing barriers that interfere with students having an equal opportunity to succeed at school. They are starting to restructure their student support services and weave them together with community resources and integrate all this with instructional efforts that affect healthy development. The intent is to develop a full continuum of programs and services encompassing efforts to promote positive development, to prevent problems, to respond as early-after-onset as is feasible, and to offer treatment regimens. Mental health and psychosocial concerns are a major focus of the continuum of interventions. Initiatives to integrate schools more fully into systems of care and the growing movement to create community schools enhance efforts to move toward comprehensive, multifaceted approaches. The following three formats are emerging:

   - Mechanisms to coordinate and integrate school and community services;

   - Initiatives to restructure student support programs and services and integrate them into school reform agendas; and

- Community schools.

(Policy Leadership Cadre for Mental Health in Schools, 2001. p. 14)

Six school-based practices that seem most integral to the success of the system of care are as follows:

- Using clinicians or other student support providers in the schools;
- Using school-based and school-focused wraparound services to support learning and transition;
- Using school-based case management;
- Providing school wide prevention and early intervention programs;
- Creating "centers" within the school to provide support to children and youth with emotional and behavioral needs and their families; and
- Using family liaisons or advocates to strengthen the roles and empowerment of family members in their children's education and care;

(Woodruff, D. W., Osher, D., Hoffman, C. C., Gruner, A., King, M. A., Snow, S. T., & McIntire, J. C., 1998. p. xiii)

Six essential elements of effective school-based mental health programs include the following:

- Programs developed and implemented on a local option basis;
- Services that include a wide range of options;
- Communication and coordination procedures established before implementing programs;
- Community agencies involved as mental health providers;
- Parents and community involvement as integral components of school based programs; and
- Technical assistance and support provided to local communities to develop innovative approaches to integrated funding sources.

(MDI Associates, 1996. pp. 4-5)

There has been very little research conducted on the effectiveness of school-based mental health programs.

The effectiveness of school-based mental health services has not been well researched. Nationally, there are a limited number of longitudinal studies on the effectiveness of school-based mental health services. Although the goal of school based mental health services is improved functioning for the child with mental health needs in all domains including home, school, and communities, most of the available research focuses on education outcomes. This research points to a series of favorable outcomes including: better behavior management in homes and classrooms; fewer disciplinary proceedings, suspensions and retentions in grades;

reductions in fighting and other forms of school violence; and, decreased reliance on costly special education programs and full-time residential placements. Despite these positive findings, there is general agreement that research on the multiple diagnostic and treatment issues involved in school-based mental health programs, has been both neglected and, when undertaken, poorly executed.

(MDI Associates, 1996. pp. 8-9)

Survey

Survey Instrument:

The survey instrument provided the respondent with both closed and open-ended items.

Using the "multi-tiered conceptual framework" (see page 9 of this document), the workgroup developed closed-ended items that reflected a continuum from prevention to early intervention to intensive intervention. Please refer to Addendum A. For each closed-ended item, the respondent was asked to rate the "Quantity and Depth" of services, as well as "Whose Responsibility" (Parents, School or Agency) it is to provide these services.

The open-ended items allowed the respondent to provide input with regard to the following questions:

- What is working in your school/community?
- What would improve services in your school/community?
- What are the advantages to providing mental health services on school property?
- What are the barriers to providing mental health services on school property?

Survey Process:

The survey was mailed to parents, school personnel, and public and private agency personnel by mid-January 2002, and collected through mid-March 2002. The table below indicates the number of surveys sent and received from each group:

Category	Number Sent	Number Returned
Teachers	2643	699
School Administrators	181	92
Agency Personnel	197	61
Parents IFFCMH	236	38
Parents IPUL*	700	142
Totals	3957	1032

*The IFFCMH parent group was sent the same two-page survey that all others received except that a question was added asking them: "If your child required mental health services, would you like to have these services provided at your child's school?" Only 38 of the 236 IFFCMH parents responded. Therefore, the survey was abbreviated to one page and mailed to 700 parents who are members of Idaho Parents Unlimited, Inc. (IPUL) (see Addendum B).

The school personnel were randomly selected from the State Department of Education database.

The Department of Health and Welfare provided the names of public and private agency personnel and all (100%) of those personnel listed received a copy of the survey.

The Idaho Federation of Families for Children's Mental Health (ICCMH) and the Idaho Parents Unlimited, Inc. (IPUL) staff assisted in sending surveys to the individuals on their respective mailing lists

Data Tabulation:

The data returned from the surveys was tabulated in the following manner:

1. For each close-ended item, the percentage of teachers, administrators, agency personnel, and parents, who indicated that the "Quality and Depth" of a service was either unknown to them or was not adequate, was calculated and entered on the survey results report (see Addendum C). The parent column reflects only the 38 parents who responded to the two-page survey. Also, the "All" column is the percentage of the teachers, administrators, and agency personnel combined.

2. The response to "Whose Responsibility" it is for each service was eliminated from the tabulation, because the prevailing pattern was to indicate that parents, schools, and agencies held an equal responsibility for the service. Therefore, this did not provide useful information.

3. For the open-ended items, the most frequent responses are presented followed by the number of respondents giving that response.

4. The responses from IPUL parents to the one page abbreviated survey were compiled on a separate report form (see Addendum D). The responses from the 38 IFFCMH parents to the same/similar questions from the two-page survey were added to this.

Findings:

- Generally, parents were less informed of, or had a more negative view of, all services offered in the entire continuum than did school or agency personnel.

- School personnel tended to hold a more positive view regarding the quality and depth of prevention and early intervention services than did agency personnel or parents.

- All groups presented a significantly more positive view of the academic accommodations available to students than for any other service.

- The respondents presented a progressively negative impression of the quality and depth of services as they moved on the continuum from prevention to intensive services.

- With respect to early interventions, school personnel tended to agree with agency personnel and parents that staff do not have the training to recognize the symptoms of emotional problems and do not have effective screening practices in place.

All of the groups participating in the survey agreed upon the following issues:

- Communication between schools, parents and agencies needs to improve and there is a need for developing formal interagency agreements.
- The provision of mental health services is a shared responsibility by the school, agencies and parents.
- Mental health assessment, information sharing, and the involvement of relevant parties in developing and monitoring treatment plans are well below their expectations for quality or depth.

- Students with severe social or emotional needs lack access to critical school and/or community services to address their needs.

- The following nine services were rated as being the most critically inadequate, unavailable, or the respondents were unaware of the service in the school/community.

    1. Respite Care
    2. Therapeutic Foster Care
    3. Job Release Time
    4. Family Preservation
    5. Companion Services
    6. Peer Mediation
    7. Day Treatment
    8. Vocational Training
    9. Outpatient Mental Health Therapy

Regarding the open-ended items, the respondents made the following observations:

- Successful school/community mental health programs are supported by the following:

    1. The availability of trained staff.
    2. Well defined programs.
    3. Effective communication among schools, agencies and parents.
    4. Alternative placements that meet individual needs.

- The greatest advantage for providing mental health services at schools was accessibility. Parents tended to favor mental health services being provided at schools on a 4 to 1 ratio.

- The greatest barriers to providing mental health services at schools included the following inadequacies/issues:

    1. Facilities/Space
    2. Funding
    3. Staffing (or Trained Staff)
    4. Time
    5. Transportation
    6. Policies Regarding Privacy
    7. Academic Scheduling

- At each meeting of the School-Based Workgroup, considerable discussion occurred regarding two potential barriers to developing a shared agenda for all partnerships. These two issues were as follows:

    1. School personnel are concerned that providing school-based mental health services will shift responsibility for primary planning and implementing services to school personnel, which may interfere with their primary mission of teaching and learning.

    2. School personnel expressed a need for well-defined protocols for private providers to follow when accessing schools and students during the school day.

Recommendations

Introduction:

The Workgroup members noted that using schools as sites for mental health services is a major challenge due to obstacles, such as space shortages and liability issues for school districts. The plan and order indicate that schools should be a "base" for mental health services to children. The definition of "base" was unclear to the Workgroup members. They chose to define the term in a broad context of schools working with the mutual support among community organizations and in a way that addresses the unique service needs of a child, not in the narrow context of whether a specific school should be the site of services for an individual child. Local schools, working in cooperation with parents, the Department of Health and Welfare and other community partners can best decide where services should be provided. Using schools as a site for providing mental health services will be difficult until the private agencies and schools have clear and concise policies and agreements regarding privacy and academic scheduling for these private providers on school premises.

A coordinated system of care for children's mental health services should include prevention, early intervention and intensive intervention. Any plan for change must acknowledge the positive contributions that schools and agencies are already making for children's mental health.

Schools need to recognize that they are natural sites/settings for the provision of Mental Health services and that this will only work when this occurs in a collaborative effort with community providers of mental health services and families. These recommendations acknowledge that schools must have the ability to manage space and resources to meet their core educational purpose.

Specific recommendations include the following:

1. In partnership with community professionals and families, schools should assess current children's mental health services and develop an improvement plan that identifies partners and responsibilities. The plan also should include a communication portion to ensure that information is shared among partners and especially with families.

2. The ICCMH, participating agencies, and local partners, including schools, should improve communications, especially with parents. Effective communication among schools, service providers, and parents is paramount for the success of the child.

3. The local Children's Mental Health Council should establish a "wrap around" service team for each child in need of intensive interventions to ensure that a comprehensive mental health assessment process is available and that treatment plans are implemented.

4. School administrator, teachers, parents, Health and Welfare, the child, family and other relevant agencies should create a community-based plan of services for individual children to be met through collaborative efforts.

5. The ICCMH should create a state team to develop a research-based document on "best practices" and address the need for technical assistance to schools and others in the community on creating community-based plans for services for individual children.

6. The Department of Education and the Department of Health and Welfare should support local schools in prevention, early intervention, parent and community education, as well as the implementation of student mental health curricula and staff development regarding children's mental health needs and services.

7. The ICCMH should submit an interagency funding request to the Legislature that creates a children's mental health collaborative fund. This fund would be for direct mental health services to support the needs of children. Local teams should determine the individual needs of children.

8. Strategies should be developed to support and engage local school trustees and other local policy-makers in meeting the mental health needs of children in their communities.

9. In committing funds and services, the ICCMH should have respite care and therapeutic foster care as priorities.

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ADDENDA

Addendum A

SCHOOL-BASED CHILDREN'S MENTAL HEALTH SURVEY
2001-2002 SCHOOL YEAR

School District_____**Position**_____

Survey Directions (Mark answers that apply with an X)
Please indicate the quantity and depth of each statement/service listed according to the practices in your school or district.
0 – Unknown
1 -- School system has not addressed this issue/service or has addressed the issue/service in little quantity and depth.
3 -- School addresses the issue/service somewhat with average quantity and depth.
5 -- School addresses the issue/service with comprehensive quantity and depth.
Please indicate who should be responsible for each of the following services with an X for all that apply.

Prevention	**Quantity and Depth**				**Whose Responsibility (Check all that apply)**		
	0	**1**	**3**	**5**	**Parents**	**School**	**Agency**
❖ Pre-K through 12 curricula, which promotes healthy social and emotional development for all students, is in place.							
❖ Students, families, and staff receive social and emotional support through information and interventions. (Such as mental health resources, fact sheets, parent education, and problem solving.)							
❖ Early identification of and intervention for academic needs are provided.							
Intervening Early After the Onset of Problems							
❖ The staff is trained to recognize symptoms of social and emotional problems in students.							
❖ Effective screening for social and emotional problems is in place.							
❖ Individual Counseling is available to students.							
❖ Group Counseling is available to students.							
❖ Crisis Intervention is available to students.							
❖ Academic accommodations are available for students.							
❖ Peer Mediation is available to students.							
❖ Behavioral Intervention Plans are available to students.							
❖ There are on-going communications between the school and the following:							
▪ Health and Welfare							
▪ Juvenile Justice Services (probation and detention)							
▪ Private mental health agencies							
▪ Doctors and other medical care providers							
❖ Formal agreements describe the coordination of mental health services between schools, private agencies and public agencies.							
Intensive Interventions for Students with Severe Social/Emotional Problems							
❖ Students with severe social and emotional needs receive a full mental health assessment as needed by the following:							
▪ School Personnel							
▪ Department of Health and Welfare							
▪ Juvenile Justice							
▪ Private Agencies							
❖ A process is in place for sharing necessary assessment information between agencies.							
❖ All relevant parties are involved in the development of comprehensive treatment plans for the student and family.							
❖ There is a process for monitoring all parties' responsibilities for the implementation of the treatment plan.							

Intensive Interventions for Students with Severe Social/Emotional Problems Continued.	**Quantity and Depth**				**Whose Responsibility (Check all that apply)**		
	0	**1**	**3**	**5**	**Parents**	**School**	**Agency**
❖ Students with severe social or emotional needs have access to school and/or community services to address the student's and/or families needs, including:							
▪ Respite Care							
▪ Alternative Educational Placements							
▪ Day Treatment							
▪ Outpatient Mental Health Therapy							
▪ Medication Monitoring							
▪ Case Management							
▪ Therapeutic Foster Care							
▪ Family Support/Education							
▪ Peer Mediation							
▪ Companion Services							
▪ Law Enforcement							
▪ Vocational Training							
▪ Anger Management							
▪ Job Release							
▪ Positive Behavioral Supports							
▪ Functional Assessments							
▪ Social Skills Training							
▪ Substance Abuse Counseling							
▪ Family Preservation							

What is working in your school/community?

What would improve services in your school/community?

What are the advantages to providing mental health services on school property? (Specifically address space availability, transportation issues, seasonal issues, and other issues.)

What are the barriers to providing Mental Health services on school property? (Specifically address space availability, transportation issues, seasonal issues, and other issues.)

Addendum B

PARENT SCHOOL-BASED CHILDREN'S MENTAL HEALTH SURVEY
2001-2002 SCHOOL YEAR

School District_____ Grade Level(s):___Pre-K___Elementary___Secondary
(Check all that apply.)

Survey Directions (Mark answers that apply with an X)
Please indicate the quantity and depth of each statement/service listed according to the practices in your school or district.
0 – Unknown
1 -- School system has not addressed this issue/service or has addressed the issue/service in little quantity and depth
3 -- School addresses the issue/service somewhat with average quantity and depth.
5 -- School addresses the issue/service with comprehensive quantity and depth.
Please indicate who should be responsible for each of the following services with an X for all that apply.

Prevention	**Quantity and Depth**				**Whose Responsibility (Check all that apply)**		
	0	**1**	**3**	**5**	**Parents**	**School**	**Agency**
❖ The school has classroom activities that promote social and emotional development.							
❖ The school offers parents information to help them provide social and emotional support to their child(ren).							
Intervening Early After the Onset of Problems							
❖ The staff at school can recognize the signs and symptoms of emotional and social problems in students.							
❖ The staff at school effectively coordinates social and emotional services with parents.							
❖ The school staff effectively communicates with private and public agencies.							
Intensive Interventions for Students with Severe Social/Emotional Problems							
❖ Students with severe social and emotional needs receive a full mental health assessment as needed.							
❖ A process is in place for involving parents in services to students with severe social/emotional problems.							
❖ The school works with other agencies to provide community-based services to students with severe social/emotional problems.							

If your child required mental health services, would you like to have these services provided at your child(ren)'s school? __Yes __No

What is working in your school/community?

What would improve services in your school/community?

What are the advantages to providing mental health services on school property? (Specifically address Space Availability, transportation issues, seasonal issues, and other issues.)

What are the barriers for providing Mental Health services on school? (Specifically address Space Availability, transportation issues, seasonal issues, and other issues.)

Addendum C

SCHOOL-BASED CHILDREN'S MENTAL HEALTH SURVEY RESULTS
2001-2002 SCHOOL YEAR

School District 3,257 Sent 890 Returned Position School Personnel/Agencies/Parents

The following percentages represent schools that are not known to address or not adequately address these Mental Health services.

Abbreviations

T--Teachers
AD -- School Administrators
AG -- Agencies
All -- School Administrators/Agencies/Teachers
P – Parents (38 who filled out the 2-page Survey filled out by School Administrators/Agencies/Teachers)

Prevention	**Quantity and Depth**				
	T	**AD**	**AG**	**All**	**P**
❖ Pre-K through 12 curricula, which promotes healthy social and emotional development for all students, is in place.	22%	15%	58%	24%	55%
❖ Students, families, and staff receive social and emotional support through information and interventions. (Such as mental health resources, fact sheets, parent education, and problem solving.)	38%	31%	52%	39%	58%
❖ Early identification of and intervention for academic needs are provided.	22%	9%	45%	22%	53%
Intervening Early After the Onset of Problems					
❖ The staff is trained to recognize symptoms of social and emotional problems in students.	45%	37%	60%	45%	82%
❖ Effective screening for social and emotional problems is in place.	49%	39%	73%	49%	89%
❖ Individual Counseling is available to students.	23%	23%	48%	25%	71%
❖ Group Counseling is available to students.	31%	25%	58%	32%	68%
❖ Crisis Intervention is available to students.	30%	18%	37%	29%	63%
❖ Academic accommodations are available for students.	11%	9%	35%	12%	39%
❖ Peer Mediation is available to students.	55%	52%	55%	54%	76%
❖ Behavioral Intervention Plans are available to students.	24%	10%	37%	23%	63%
❖ There are on-going communications between the school and the following:					
▪ Health and Welfare	47%	23%	43%	44%	79%
▪ Juvenile Justice Services (probation and detention)	50%	28%	52%	48%	61%
▪ Private mental health agencies	67%	49%	65%	65%	87%
▪ Doctors and other medical care providers	58%	41%	77%	57%	89%
❖ Formal agreements describe the coordination of mental health services between schools, private agencies and public agencies.	75%	60%	68%	73%	89%
Intensive Interventions for Students with Severe Social/Emotional Problems					
❖ Students with severe social and emotional needs receive a full mental health assessment as needed by the following:					
▪ School Personnel	41%	33%	63%	42%	82%
▪ Department of Health and Welfare	74%	66%	28%	70%	76%
▪ Juvenile Justice	78%	68%	73%	76%	79%
▪ Private Agencies	79%	62%	60%	76%	76%
❖ A process is in place for sharing necessary assessment information between agencies.	62%	37%	48%	58%	82%
❖ All relevant parties are involved in the development of comprehensive treatment plans for the student and family.	53%	43%	47%	51%	76%
❖ There is a process for monitoring all parties' responsibilities for the implementation of the treatment plan.	65%	62%	60%	65%	87%

Intensive Interventions for Students with Severe Social/Emotional Problems Continued.	0-1
	All
❖ Students with severe social or emotional needs have access to school and/or community services to address the student's and/or families needs, including:	
▪ Respite Care	83%
▪ Therapeutic Foster Care	82%
▪ Outpatient Mental Health Therapy	78%
▪ Job Release	78%
▪ Family Preservation	78%
▪ Companion Services	74%
▪ Peer Mediation	69%
▪ Vocational Training	68%
▪ Day Treatment	66%
▪ Substance Abuse Counseling	63%
▪ Case Management	60%
▪ Family Support/Education	60%
▪ Functional Assessments	58%
▪ Social Skills Training	57%
▪ Anger Management	56%
▪ Law Enforcement	52%
▪ Positive Behavioral Supports	51%
▪ Medication Monitoring	50%
▪ Alternative Educational Placements	47%

Intensive Interventions for Students with Severe Social/Emotional Problems Continued.	0-1
	Parents
❖ Students with severe social or emotional needs have access to school and/or community services to address the student's and/or families needs, including:	
▪ Respite Care	95%
▪ Therapeutic Foster Care	95%
▪ Job Release	89%
▪ Peer Mediation	87%
▪ Family Preservation	87%
▪ Companion Services	84%
▪ Day Treatment	82%
▪ Vocational Training	82%
▪ Anger Management	82%
▪ Outpatient Mental Health Therapy	79%
▪ Case Management	76%
▪ Family Support/Education	76%
▪ Positive Behavioral Supports	76%
▪ Functional Assessments	76%
▪ Substance Abuse Counseling	76%
▪ Medication Monitoring	74%
▪ Social Skills Training	71%
▪ Law Enforcement	68%
▪ Alternative Educational Placements	63%

What is working in your school/community? Staff **(212**), Specific Programs such as SED, DARE, SOS, Substance Abuse and After School (**104**), Alternative Placement (includes: Schools, Day Treatment, Therapeutic Learning Center (TLC) (**80**), Communication between School, Service Providers, Parents, Agencies and etc. (**43**)
What would improve services in your school/community? Communication w/School, Service Providers, Parents, Agencies (Public and Private), Community and etc. (**131**), More Staff (**165**), More Resources and a List/Pamphlet of Available Resources (**104**), Training for Teachers, Staff, and Parents (**94**), Funding (**66**), Parent Involvement (**66**), Alternative Placement (**45**)
What are the advantages to providing mental health services on school property? (Specifically address space availability, transportation issues, seasonal issues, and other issues.) Accessibility **(142)**, Immediate Access to Services **(110)** and Academic Schedule **(36)**
What are the barriers to providing Mental Health services on school property? (Specifically address space availability, transportation issues, seasonal issues, and other issues) Space **(313)**, Funding **(152)**, Not Enough Staff **(112)**, Time **(64)**, Transportation **(62)**, Confidentiality and Privacy **(67)**, Academic Schedule **(54)** and Trained Staff **(53)**.

Addendum D

PARENT SCHOOL-BASED CHILDREN'S MENTAL HEALTH SURVEY RESULTS
2001-2002 SCHOOL YEAR

School District_936 Sent_ 180 Received_ Grade Level(s): 53 Pre-K 107 Elementary 101 Secondary
(Check all that apply.)

Survey Directions (Mark answers that apply with an X)
Please indicate the quantity and depth of each statement/service listed according to the practices in your school or district.
0 – Unknown
1 -- School system has not addressed this issue/service or has addressed the issue/service in little quantity and depth.
3 -- School addresses the issue/service somewhat with average quantity and depth.
5 -- School addresses the issue/service with comprehensive quantity and depth.

Prevention	**Quantity and Depth**	
	0-1	**3-5**
❖ The school has classroom activities that promote social and emotional development.	36%	64%
❖ The school offers parents information to help them provide social and emotional support to their child(ren).	52%	48%
Intervening Early After the Onset of Problems		
❖ The staff at school can recognize the signs and symptoms of emotional and social problems in students.	49%	51%
❖ The staff at school effectively coordinates social and emotional services with parents.	59%	41%
❖ The school staff effectively communicates with private and public agencies.	68%	32%
Intensive Interventions for Students with Severe Social/Emotional Problems		
❖ Students with severe social and emotional needs receive a full mental health assessment as needed.	66%	34%
❖ A process is in place for involving parents in services to students with severe social/emotional problems.	62%	38%
❖ The school works with other agencies to provide community-based services to students with severe social/emotional problems.	72%	28%

If your child required mental health services, would you like to have these services provided at your child(ren)'s school? **121** Yes **31** No

What is working in your school/community? Caring Staff (30), Counselors and Counseling (18), and Communication w/School, Service Providers, Parents, Agencies (Public and Private), Community and etc. (14)

What would improve services in your school/community? More Caring Staff (58), Provide Mental Health Training for Staff (24), Communication w/School, Service Providers, Parents, Agencies (Public and Private), Community and etc. (22), More Funding (16), Provide Information on Resources (11), More Awareness of Mental Health Issues (10)

What are the advantages to providing mental health services on school property? (Specifically address Space Availability, transportation issues, seasonal issues, and other issues.) Accessibility of Services (36), Transportation (22), Academic Schedule (14), Convenience (12), Immediate Access to Services (10), Services Provided On-site (9), and a Safe Environment (9).

What are the barriers for providing Mental Health services on school? (Specifically address Space Availability, transportation issues, seasonal issues, and other issues.) Space (51), Funding (33), Training (23), Staff (18), Transportation (15), Academic Schedule (15), Labeling Students (13), and Time (13)